

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

23676

FILED AUG 2 - 1955

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. <b>5549</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>				STREET ADDRESS (If rural, give location) <b>3039 Dickson</b> <span style="float: right;">2216</span>					
3. NAME OF DECEASED a. (First) <b>Mary</b> (Type or Print)			b. (Middle) _____		c. (Last) <b>Eckford</b>		4. DATE OF DEATH (Month) <b>6</b> (Day) <b>22</b> (Year) <b>55</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>9-18-1909</b>		9. AGE (in years last birthday) <b>45</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Eligea Jarman</b>			13b. MOTHER'S MAIDEN NAME <b>Alice Robinson</b>			14. NAME OF HUSBAND OR WIFE <b>Joe Eckford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Joe Eckford</b> ADDRESS <b>3039 Dickson St</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Diabetic Acidosis - With Coma?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral Thrombosis ?</b>							
		19a. DATE OF OPERATION _____							
19b. MAJOR FINDINGS OF OPERATION _____		21a. ACCIDENT (Specify) _____ SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>260x</b>					
22. I hereby certify that I attended the deceased from <b>6-20</b> , 19 <b>55</b> , to <b>6-22</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>6-22</b> , 19 <b>55</b> , and that death occurred at <b>11:20p.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Edw. B. Williams M.D.</b>				23b. ADDRESS <b>2601 N. Whittier.</b>			23c. DATE SIGNED <b>6-23-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-28-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Heaborn</b>		24d. LOCATION (City, town, or county) (State) <b>Abbeardon Mississippi</b>			
DATE REC'D BY LOCAL REG. <b>JUN 25 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith - M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ellis Funeral Home Inc. 2820 Stoddard St.</b>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Gordon E. Culhane*

Licensed Embalmer No. *410*

P. O. Address *R. H. ...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.